APPLICATION FOR PRESCRIPTIVE AUTHORITY AS AN ADVANCED PRACTICE NURSE

State Form 50025 (R / 2-06)
Approved by State Board of Accounts, 2006

INDIANA STATE BOARD OF NURSING
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2043
E-mail: pla2@pla.IN.gov

INSTRUCTIONS: Please type or print clearly.

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

FOR OFFICE USE ONLY		
Application fee	Date fee paid (*month, day, year*)	Receipt number
Prescriptive authority number	Date of issuance (*month, day, year*)	

DO NOT WRITE ABOVE THIS LINE

Please check one of the following indicating the category of Advanced Practice Nurse:

☐ **Clinical Nurse Specialist** ☐ **Nurse Practitioner** ☐ **Certified Nurse Midwife**

Area of practice / specialty:

APPLICANT INFORMATION	
Name (*last, first, middle, maiden*) (*include any names EVER used*)	
Address (*number and street or rural route, city, state, and ZIP code*)	
Date of birth (*month, day, year*)	Place of birth (*city and state*)
Social Security number *	Telephone number (*include area code*) ( )
E-mail address	

LIST ALL CURRENT OFFICE ADDRESSES & TELEPHONE NUMBERS

NUMBER AND STREET	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )
				( )
				( )
				( )
				( )
				( )

LIST ALL NURSING EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED	DEGREE(S) GRANTED

LIST ALL NAMES AND ADDRESSES OF EMPLOYERS AND RESPONSIBILITIES HELD OR PERFORMED SINCE GRADUATION FROM NURSING SCHOOL

LIST ALL STATES, INCLUDING *INDIANA*, IN WHICH YOU HAVE BEEN LICENSED, CERTIFIED, OR REGISTERED TO PRACTICE ANY REGULATED HEALTH OCCUPATION

STATE	PROFESSION	NUMBER ISSUED	DATE ISSUED	STATUS

LIST THE NAME AND LICENSE NUMBER OF THE COLLABORIATING PHYSICIAN(S)

Name	License Number

If your answer is "**Yes**" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the prescriptive authority issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in **any** state or country? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a nurse or **any** regulated health occupation in **any** state or country? ☐ Yes ☐ No
3. Are there charges pending against you regarding a violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol or other drugs? ☐ Yes ☐ No
4. Have you ever been convicted of, pled guilty or nolo contendre to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol or other drugs? ☐ Yes ☐ No
   B. To any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No
5. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or as another health care professional? ☐ Yes ☐ No
6. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No
7. Are you now, or have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for prescriptive authority as an Advanced Practice Nurse.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency and the Indiana State Board of Nursing from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

Signature of applicant	Date (*month, day, year*)

PLEASE TAPE YOUR PHOTOGRAPH BELOW

(*You must place your signature on the front of your photograph.*)